Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2002

Department of Health & Family Services
Division of Disability and Elder Services
Bureau of Aging & Long Term Care Resources

Executive Summary

The Community Options Program (COP) began with the passage of the 1981 state budget. The purpose of the program was to create a home and community-based alternative to nursing home care. Wisconsin had a high use of nursing homes, with dramatic annual increases in nursing home spending. The Community Options Program was intended to offer more choices for older people and people with disabilities at a lower cost to the state. In 1986, Wisconsin received a federal Medicaid Home and Community-Based Waiver for people who are elderly or have a physical disability, which allowed the state to get federal matching funds for COP with some flexibility in how it would meet the Title 19 (Medicaid) requirements. The Community Options Program serves a limited number of people and is not an entitlement.

The Community Options Program General Purpose Revenue (GPR) serves people who are elderly or who have a physical, developmental or mental disability. The COP Medicaid waiver serves only people who are elderly or have a physical disability. Three other waivers serve people with developmental disabilities.

In 2002, the state and federal government spent $184,208,026 on the Community Options Program and the Community Options Program waivers administered by all counties and one tribe. This is equal to about 42 percent of the total spending on all home and community-based waiver programs (Appendix B). Waivers for people with developmental disabilities spent $252,678,519 in 2002.

Individuals who use waiver services are also eligible for the Medicaid card benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in the Community Integration Program II (CIP II) and the Community Options Program-Waiver (COP-W) used $107,950,951 in benefits from their Medicaid card. The largest expenditures were, not surprisingly, for prescription drugs ($36 million) and personal care ($28 million).

The *average* daily cost of care for participants in CIP II and COP-W in CY 2002 was $74.76. This includes state and federal funds and Supplemental Security Income, totaling $268.2 million per year. The *average* daily cost of care for persons at the same mix of levels of care living in nursing homes was $100.45 of Medicaid funds. Hypothetically, if all of the CIP II and COP-W participants had entered nursing homes last year, the total cost would have been about $360.3 million for the year, instead of $268.2 million.

About two-thirds of COP and all waiver participants received care in their own homes or apartments; only 15 percent were living in community-based residential facilities (CBRF). A majority of the participants also had family or friends involved in providing voluntary care. Quality assurance reviews measured high rates of consumer satisfaction, especially for people living in their own homes.

In 2000, the introduction of Family Care (a comprehensive long-term care benefit) began in five Wisconsin counties. Consequently, in 2002 there was a decline in the numbers of COP, COP-W and CIP II participants in those counties as participants transferred into the Family Care program.

Table of Contents

Table of Contents (cont.)

INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The statutes also permit COP funds to be used with the flexibility to expand Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40:60. The Community Options Program-Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. The Community Options Program-Waiver also includes the Community Integration Program II (CIP II).

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), Community Integration Program 1B (CIP 1B) and Community Supportive Living Arrangements (CSLA) all serve the community needs for long-term care participants with developmental disabilities. Brain Injury Waiver (BIW) serves individuals who have received brain injury rehabilitation. The Community Options Program state funding is often used as a match for federal funds through these waivers.

This report describes the persons served, program expenditures and services delivered primarily through COP, COP-W and CIP II in calendar year 2002 (all waivers were reported where data was available). Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP, provide a comprehensive health care package to recipients. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help to contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Community Options Program and Community Options Program-Waiver funds are administered by the Department of Health and Family Services, and the programs are managed by county agencies. These funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations.

The success of the Community Options Program is measured both by how well the program is able to help contain the use and cost of Medicaid-funded nursing home care, and by producing positive outcomes for the program participants. Both COP and COP-W together provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The coordination of county resources is outlined in the local Community Options Program Plan, a description of the county policies and practices, which assures the prudent, cost-effective operation of the Community Options Program. Each county COP plan is updated annually with approval by the local Long-Term Support Planning Committee.

State level program management monitors local compliance with statutory program requirements, including:

- significant proportions;
- allowable residential settings;
- county COP plan approval; and
- the mandated use of the federally-funded home and community-based Medicaid waivers prior to using the state-funded COP.

PARTICIPANTS SERVED BY PROGRAMS

The following table provides information about the numbers of participants in various waiver programs. The Community Options Program, in combination with Medicaid waiver funds, is used to support individuals in the community. The program category column in Table 1 lists each funding source by type of Medicaid waiver, and when each waiver is combined with COP funding. (See Appendix B for definitions of community long-term care programs.) The categories of participants are (vertical) elderly, persons with physical disabilities (PD), persons with developmental disabilities (DD), persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse (AODA).

TABLE 1

Participants Served by Programs During 2002 (Full Year) with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Other	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W									**9,376**
Waiver Only	4,866	1,669					6,535		
Waiver/COP	2,300	541						2,841	
CIP II									**3,641**
Waiver Only	1,081	1,327					2,408		
Waiver/COP	728	505						1,233	
Sub Total COP-W/CIP II	**8,975**	**4,042**					**8,943**	**4,074**	**13,017**
CIP 1A									**1,132**
Waiver Only	35		1,020				1,055		
Waiver/COP	6		71					77	
CIP 1B Regular									**2,738**
Waiver Only	172		2,434				2,606		
Waiver/COP	7		125					132	
CIP 1B/CSLA COP Match									**2,454**
Waiver/COP for match only	92		2,027				2,119		
COP match waiver w/other COP	21		314					335	
CIP 1B/CSLA Other Match									**3,937**
Waiver/other for match	157		3,686				3,843		
Waiver/COP	6		88					94	
Brain Injury Waiver									**225**
Waiver Only	0	136	66				202		
Waiver/COP	0	19	4					23	
Brain Injury COP Match									**1**
Waiver/COP for match only	0	1	0				1		
COP match waiver w/other COP	0	0	0					0	
Brain Injury Waiver Other Match									**42**
Waiver/other for match	0	25	15				40		
Waiver/COP	0	1	1					2	
Sub Total Developmental Disabilities Waivers	**496**	**182**	**9,851**				**9,866**	**663**	**10,529**
COP Only Participants	**447**	**161**	**122**	**909**	**10**	**2**			**1,651**
Totals by Target Population	**9,918**	**4,385**	**9,973**	**909**	**10**	**2**	**18,809**	**4,737**	**TOTAL 25,197**
% Served by Target Population	**39.4%**	**17.4%**	**39.6%**	**3.6%**	**0.04%**	**0.01%**	**74.6%**	**18.8%**	

NOTE: Participants with a dual diagnosis are counted under the funding program.

- Total unduplicated participants served in 2002 - 25,197.
- Total participants who were served by a Medicaid waiver only (no COP funds) – 18,809.
- Total Medicaid waiver participants who also received COP funding in CY 2002 - 4,737.
- Total participants who received only COP funding (not Medicaid eligible) - 1,651.
- All participants who received either pure COP or COP supplementing funds - 6,388.
- Total participants served with COP and COP-W funds - 15,043.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 25,197 persons. The table below illustrates participants served with COP and Medicaid waiver funding by target group in 2002.

TABLE 2
Participants Served by Target Group During 2002 (Full Year) with COP and all Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CLSA, BIW	GRAND TOTAL
Elderly	447 27.1%	7,166 76.4%	**7,613** **69.0%**	132 4.7%	1,809 49.7%	**9,554** **54.7%**	364 4.7%	**9,918** **39.4%**
PD	161 9.8%	2,210 23.6%	**2,371** **21.5%**	21 0.8%	1,832 50.3%	**4,224** **24.2%**	161 2.1%	**4,385** **17.4%**
DD	122 7.4%	0 0%	**122** **1.1%**	2,630 94.5%	0 0%	**2,752** **15.8%**	7,221 93.2%	**9,973** **39.6%**
SMI	909 55.1%	0 0%	**909** **8.2%**	0 0%	0 0%	**909** **5.2%**	0 0%	**909** **3.6%**
AODA	10 0.6%	0 0%	**10** **0.1%**	0 0%	0 0%	**10** **0.1%**	0 0%	**10** **0.04%**
Other	2 0.1%	0 0%	**2** **0.0%**	0 0%	0 0%	**2** **0.0%**	0 0%	**2** **0.01%**
Total	**1,651** **6.6%**	**9,376** **37.2%**	**11,027** **43.8%**	**2,783** **11%**	**3,641** **14.5%**	**17,451** **69.3%**	**7,746** **30.7%**	**25,197** **100.0%**

Note: Totals may not equal 100% due to rounding.

- 9,918 or 39% were elderly;
- 4,385 or 17% were persons with physical disabilities (PD);
- 9,973 or 40% were persons with developmental disabilities (DD);
- 909 or 4% were persons with severe mental illness (SMI); and
- 12 or 1% were persons with alcohol and/or drug abuse (AODA) or other conditions.

FIGURE 1
Participants Served by Target Group During 2002 (Full Year) with COP and All Waivers

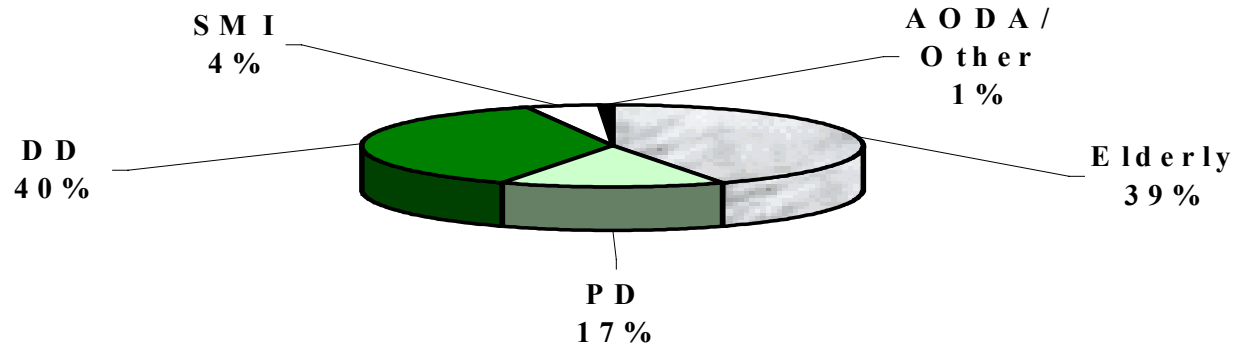
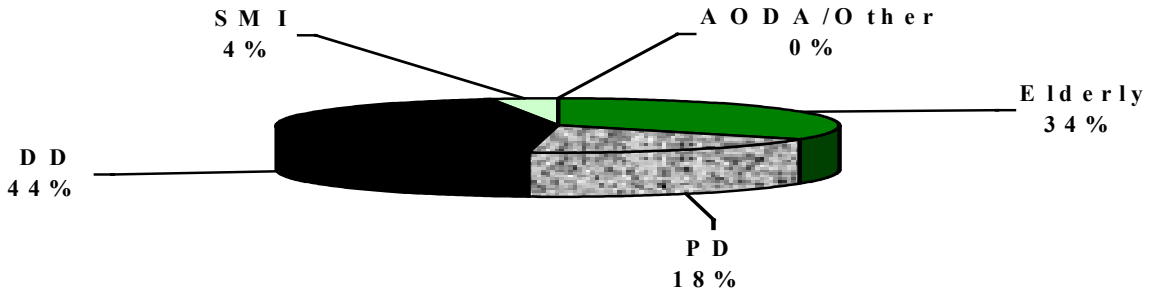


TABLE 3
Participants Served by Programs on December 31, 2002 (Point-In-Time) with COP and All Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Other	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W									**7,101**
Waiver Only	3,775	1,558					5,333		
Waiver/COP	1,387	381						1,768	
CIP II									**2,980**
Waiver Only	920	1,288					2,208		
Waiver/COP	424	348						772	
Sub Total COP-W/CIP II	**6,506**	**3,575**					**7,541**	**2,540**	**10,081**
CIP 1A									**1,089**
Waiver Only	33		991				1,024		
Waiver/COP	4		61					65	
CIP 1B Regular									**2,652**
Waiver Only	162		2,382				2,544		
Waiver/COP	4		104					108	
CIP 1B/CSLA COP Match									**2,369**
Waiver/COP for match only	80		1,987				2,067		
COP match waiver w/other COP	20		282					302	
CIP 1B/CSLA Other Match									**3,804**
Waiver/other for match	146		3,586				3,732		
Waiver/COP	3		69					72	
Brain Injury Waiver									**219**
Waiver Only	0	134	65				199		
Waiver/COP	0	17	3					20	
Brain Injury COP Match									**1**
Waiver/COP for match only	0	1	0				1		
COP match waiver w/other COP	0	0	0					0	
Brain Injury Waiver Other Match									**40**
Waiver/other for match	0	24	16				40		
Waiver/COP	0	0	0					0	
Sub Total Developmental Disabilities Waivers	**452**	**176**	**9,546**				**9,607**	**567**	**10,174**
COP Only Participants	**327**	**145**	**109**	**819**	**8**	**1**			**1,409**
Totals by Target Population	**7,285**	**3,896**	**9,655**	**819**	**8**	**1**	**17,148**	**3,107**	**TOTAL 21,664**
% Served by Target Population	**33.6%**	**18.0%**	**44.6%**	**3.8%**	**0.0%**	**0.0%**	**79.2%**	**14.3%**	

NOTE: Participants with a dual diagnosis are counted under the funding program.

FIGURE 2 - Point-in-Time Participants Served by Target Group with COP and All Waivers on 12/31/02



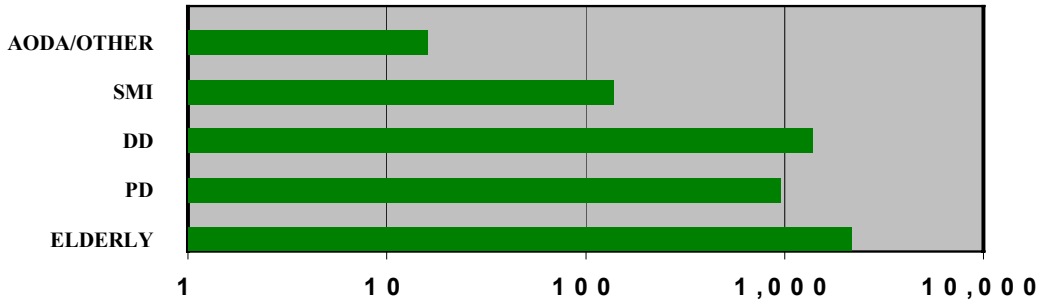
ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2002, 9,005 assessments were conducted, and 6,258 care plans were prepared.

NEW PERSONS

Figure 3 illustrates the target group distribution of new persons served during 2002. The majority of the new participants served in 2002 were elderly. Clients are considered new 2002 service clients if they have 2002 services and costs and no long-term support services of any type in 2001.

FIGURE 3
New Persons Receiving Services by Target Group in 2002
For COP and All Waivers



AODA/Other	SMI	DD	PD	Elderly
29 (0.6%)	159 (3.3%)	1,378 (28.2%)	985 (20.2%)	2,329 (47.7%)

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2002 for various reasons. Approximately 15 percent of all participants' cases were closed during 2002. About 46 percent of elderly case closures and 46 percent of closures of persons with physical disabilities were due to death. Approximately 31 percent of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 37 percent were due to moving to an institution.

TABLE 4
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	1,254	245	104	26	2	8	1,639
Moved to Hospital/Nursing Facility or Other Institution	1,014	81	50	13	3	2	1,163
Transferred to Partnership Program	4	2	1	0	0	0	7
No Longer Income or Care Level Eligible	99	47	12	10	0	0	168
Voluntarily Ended Services	169	65	44	54	1	5	338
Moved	130	82	78	16	0	1	307
Other	69	10	7	2	o	3	91
Total Case Closed (all reasons)	**2,739**	**532**	**296**	**121**	**6**	**19**	**3,713**

SIGNIFICANT PROPORTIONS AND TARGET GROUPS SERVED WITH COP AND COP-W FUNDS

Community Options Program and COP-Waiver program funding is intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP funding serve persons from the major target groups in proportions that approximate the percentages of Medicaid-eligible persons who are served in nursing homes or state institutions. These percentages are called "significant proportions".

The minimum percentages for significant proportions were initially set in 1984 and have been periodically adjusted to reflect changes in the growth of the long-term care population. The percentage for elderly has been set lower than the actual population to allow some county flexibility. The total minimum percentages add up to 84.2 percent with 15.8 percent reserved for county discretion.

TABLE 5A
Detail of 2002 Significant Proportions and Target Groups

2002

	Elderly	PD	DD	SMI	AODA	Other	Total
Total served excluding the Partnership Program and Milwaukee County Disability Services[1]	**6,014**	**1,681**	**2,500**	**659**	**8**	**1**	**10,863**
Percentage for above total	55.4%	15.5%	23.0%	6.1%	0.1%	0.0%	100%
Partnership Program participants served[2]	707	488	0	0	0	0	1,195
Total including the Partnership Program participants	**6,721**	**2,169**	**2,500**	**659**	**8**	**1**	**12,058**
Percentage for above total	55.7%	18.0%	20.7%	5.5%	0.1%	0.0%	100%
Participants served by Milwaukee County Disability Services[3]	17	742	838	160	0	0	1,757
Standard Methodology (including the above participants)[4]	**6,738**	**2,911**	**3,338**	**819**	**8**	**1**	**13,815**
Percentage for above total	48.8%	21.1%	24.2%	5.9%	0.1%	0.0%	100.0%

TABLE 5B
Individuals and Percentages Used for Monitoring Significant Proportions 1999 – 2002

1999 - 2002

Year	Elderly	PD	DD	SMI	AODA	Other	Total
2002[4]	6,738 48.8%	2,911 21.1%	3,338 24.2%	819 5.9%	8 0.1%	1 0.0%	**13,815[4]** 100%
2001	6,430 50.9%	2,035 16.1%	3,106 24.6%	967 7.7%	29 0.2%	68 0.5%	**12,635** 100%
2000	7,972 56.1%	2,062 14.5%	3,155 22.2%	993 7.0%	23 0.2%	0 0%	**14,205** 100%
1999	8,875 57.3%	2,306 14.9%	3,221 20.8%	1,068 6.9%	25 0.2%	0 0%	**15,495** 100%
Minimum Percentages	**57.0%**	**6.6%**	**14.0%**	**6.6%**	**0%**		

Note: Counts reflect individuals served with COP and COP-W funding on December 31st of each year with adjustments applied.

1. These numbers include calculation for COP funding used as overmatch and for county specific variances. They do not include individuals served by Milwaukee County Disability Services or those served by the Partnership Program who count for significant proportions.
2. Numbers of individuals served by the Partnership Program in Chippewa, Dunn, Eau Claire and Milwaukee County Disability Services who are counted for significant proportions.
3. Numbers of individuals served by Milwaukee County Disability Services with COP and COP-W funding.
4. Unduplicated count of individuals whose services are funded with COP Regular, COP-W or CIP IB when COP funding is used to provide the local match. The numbers include a calculation adjustment to factor in the amount of COP funding that is used as match for services above the CIP I and CIP II rate. (This methodology counts approximately one additional person for every $10,000 of COP regular funds used in this way.) Totals include adjustments for county specific variances and persons served by the Partnership Program and Milwaukee County Disability Services.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-Waiver participants received services for three years or less. The other one-third of program participants are longer-term participants, receiving services for as long as ten years.

Turnover is defined as the number of new participants who need to be added in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25 percent.

Table 6 illustrates the number of cases closed during 2002 divided by the caseload size on December 31, 2001 for each target group. The shaded row of Table 6 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2003.)

TABLE 6
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2002	9,918	4,385	9,973	909	10	2	25,197
Point-in-Time Number of Persons Served on December 31, 2002	7,285	3,896	9,655	819	8	1	21,664
Number of Cases Closed During 2002 (Excludes Transfers to the Family Care & Partnership Programs)	2,739	532	296	121	6	19	3,713
Point-in-Time Number of Persons Served on December 31, 2001 (Caseload Size)	7,486	3,279	8,710	863	14	17	20,369
Turnover Rate for the Above Case Closures	37%	16%	3%	14%	43%	n/a	18%

COP FUNDING FOR EXCEPTIONAL NEEDS

The statewide Community Options Program fund for exceptional needs is part of COP. The Department may carry forward to the next fiscal year, COP and COP-W GPR funds allocated but not spent by December 31 (s. 46.27(7)(g), Wis. Stats.). These exceptional funds are made available to applicant counties for the improvement or expansion of long-term community support services for clients. Services may include:

a) start-up costs for developing needed services for eligible target groups;

b) home modifications for COP eligible participants and housing funding;

c) purchase of medical services and medical equipment or other specially adapted equipment; and

d) vehicle modifications.

In 2002, funds for exceptional needs were awarded to 44 counties. For example, individual awards include "homecoming" funds that allow people to purchase or pay for household furnishings, equipment, security deposits, etc., so they can move from an institution into the community. Awards were made for home repairs and modifications such as ramps, mobility lifts, overhead track lifts, roll-in showers, raised toilets, lowered cabinets and fixtures, grab bars, wider hallways and doors, door openers, automatic controls for windows, lights, temperature devices, adapted beds, adapted chairs, etc. Awards were also made for adapted mobility equipment such as wheelchairs, walkers and scooters not covered by Medicaid, as well as van modifications.

TABLE 7
COP and All Waiver Participants Served in 2002

PARTICIPANTS SERVED IN 2002	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
COP Only	447	161	122	909	12	1,651	6.6%
COP-W	7,166	2,210	0	0	0	9,376	37.2%
All Other COP Used as Match	132	21	2,630	0	0	2,783	11.0%
CIP II	1,809	1,832	0	0	0	3,641	14.5%
CIP I, CLSA and BIW	364	161	7,221	0	0	7,746	30.7%
TOTAL	9,918	4,385	9,973	909	12	25,197	100%

NOTE: Participants with a dual diagnosis are counted under the funding program.

TABLE 8
Census 2000 – Wisconsin Population by Race/Ethnic Background

WISCONSIN POPULATION IN RACE GROUPS – ALL AGES FROM CENSUS 2000	NUMBER	PERCENT
Caucasian	4,769,857	88.9%
African American	304,460	5.7%
American Indian/Native American	47,228	0.9%
Asian	88,763	1.7%
Other	153,367	2.9%
TOTAL	5,363,675	100%
*Hispanic/Latino (all races)	*192,921	*3.6%

SOURCE: 2000 Census NOTE: *The U.S. Census considers "Hispanic/Latino" an ethnicity, not a race. "Hispanic/Latino" is reported in addition to race, and is not included in the race totals or percents in this table.

TABLE 9
COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	8,972	3,414	9,113	964	95	22,558	90%
African American	566	572	490	110	23	1,761	7%
Hispanic	76	65	103	7	2	253	1%
American Indian/Alaska Native	126	71	108	13	5	323	1%
Asian/Pacific Islander	176	41	70	7	1	295	1%
Unknown	2	0	5	0	0	7	0%
TOTAL	9,918	4,163	9,889	1,101	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 10
COP and All Waiver Participants who Relocated/Diverted from Institution

RELOCATED/DIVERTED	NUMBER	PERCENT
Diverted from Entering any Institution	21,618	86%
Relocated form General Nursing Home	1,568	6%
Relocated from ICF/MR	1,761	7%
Relocated from Brian Injury Rehab Unit	195	1%
Other	55	.22%
TOTAL	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 11
COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	7,400	2,368	4,423	585	68	14,844	59%
Male	2,518	1,795	5,466	516	58	10,353	41%
TOTAL	9,918	4,163	9,889	1,101	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 12
COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	85	833	8	0	926	4%
18 – 64 years	0	4,078	9,056	1,093	126	14,353	57%
65 – 74 years	3,033	0	0	0	0	3,033	12%
75 – 84 years	3,806	0	0	0	0	3,806	15%
85 years and over	3,079	0	0	0	0	3,079	12%
TOTAL	9,918	4,163	9,889	1,101	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 13
COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	4,821	207	31	23	18	5,100	20%
Never Married	1,440	1,630	9,536	730	34	13,370	53%
Married	2,079	951	123	72	24	3,249	13%
Divorced/Separated	1,389	1,296	166	255	39	3,145	13%
Unknown	189	79	33	21	11	333	1%
TOTAL	9,918	4,163	9,889	1,101	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 14
COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	4,743	635	21	60	28	5,487	22%
Non-Relative	1,190	773	1,991	254	28	4,236	17%
Spouse	1,613	845	68	52	14	2,592	10%
Parent	85	1,010	5,883	269	12	7,259	29%
Other Relative	1,479	532	1,154	148	24	3,337	13%
No Primary Support	806	369	762	316	19	2,272	9%
Other	2	0	10	1	1	14	0%
TOTAL	9,918	4,164	9,889	1,100	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 15
COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	2,744	1,695	3,790	148	32	8,409	33%
Living Alone	3,871	1,080	618	406	38	6,013	24%
Living with Others with Attendant Care	1,581	392	2,797	284	27	5,081	20%
Living with Others	730	309	1,926	208	12	3,185	13%
Living Alone with Attendant Care	524	324	347	34	8	1,237	5%
Living with Immediate Family with Attendant Care	288	283	275	4	3	853	3%
Living with Extended Family	139	63	117	9	4	332	1%
Living with Extended Family with Attendant Care	30	10	15	1	0	56	.22%
Transient Housing Situation	11	7	2	5	0	25	.10%
Other	0	1	2	1	2	6	.02%
TOTAL	9,918	4,164	9,889	1,100	126	25,197	100%

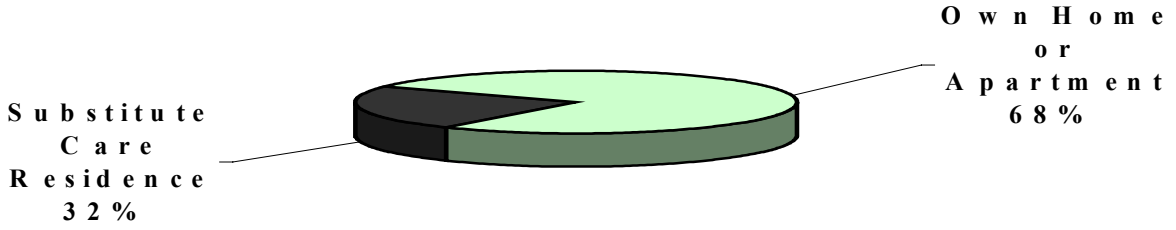
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

TABLE 16
COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	2	70	1	0	73	.29%
Adult Family Home (AFH)	443	156	1,886	123	7	2,615	10%
Brain Injury Rehab Unit	1	7	4	0	0	12	.05%
Child Group Home	0	2	7	1	0	10	.04%
Community Based Residential Facility (CBRF)	1,585	230	1,655	314	28	3,812	15%
Foster Home	54	17	321	11	2	405	2%
ICF/MR (Not State Center)	0	0	2	0	0	2	.01%
Nursing Home	7	1	2	0	0	10	.04%
Other Living Arrangement	3	0	2	0	1	6	.02%
Own Home or Apartment	7,595	3,687	5,075	599	86	17,042	68%
Residential Care Apartment Complex (RCAC)	133	10	0	1	0	144	.57%
Residential Care Center (RCC)	2	1	1	1	0	5	.02%
Shelter Care Facility	1	2	2	2	0	7	.03%
State DD Center	0	0	1	0	0	1	.00%
Supervised Community Living	94	49	861	45	1	1,050	4%
Unknown	1	0	0	2	1	3	.01%
TOTAL	9,918	4,164	9,889	1,100	126	25,197	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program.

FIGURE 4
Percentage of Participants in Own Home or Substitute Care Residence



COP AND ALL HOME COMMUNITY-BASED WAIVER FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $436,886,545 (federal waiver and state funds) was spent in 2002 on Community Options and all long-term care Medicaid Home and Community-Based Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 13 percent of the overall total. COP-Regular and COP-Waiver together contribute 31 percent of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

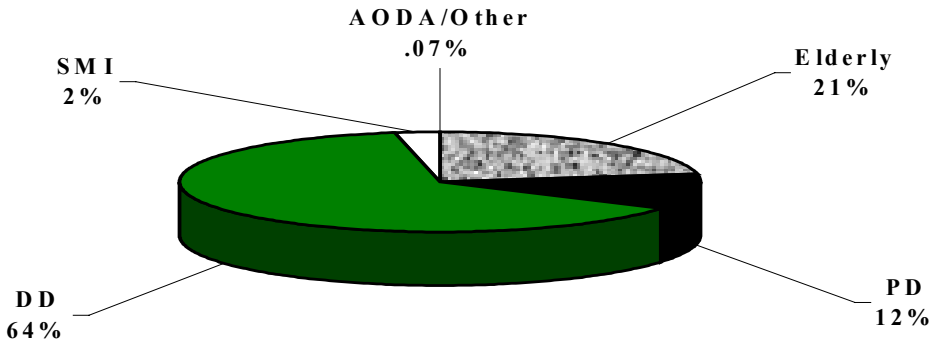
TABLE 17
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2002

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLSA, BIW	GRAND TOTAL
Elderly	12,415,465 0.21%	56,065,439 72.1%	**68,480,904 50.4%**	21,750,118 45.0%	**90,231,022 49.0%**		**90,231,022 20.65%**
PD	6,095,576 0.10%	21,695,225 27.9%	**27,790,801 20.5%**	26,583,478 55.0%	**54,374,279 29.5%**		**54,374,279 12.45%**
DD	29,066,279 0.50%		**29,066,279 21.4%**		**29,066,279 15.8%**	252,678,519 100%	**281,744,798 64.49%**
SMI	10,202,676 0.18%		**10,202,676 7.5%**		**10,202,676 5.5%**		**10,202,676 2.34%**
AODA	182,770 0.00%		**182,770 .1%**		**182,770 0.1%**		**182,770 0.04%**
Other	151,000 0.00%		**151,000 .1%**		**151,000 0.1%**		**151,000 0.03%**
Total	**$58,113,766 13.3%**	**$77,760,664 17.8%**	**$135,874,430 31.1%**	**$48,333,596 11.1%**	**$184,208,026 42.2%**	**$252,678,519 57.8%**	**$436,886,545 100.0%**

Source: Reconciliation schedules

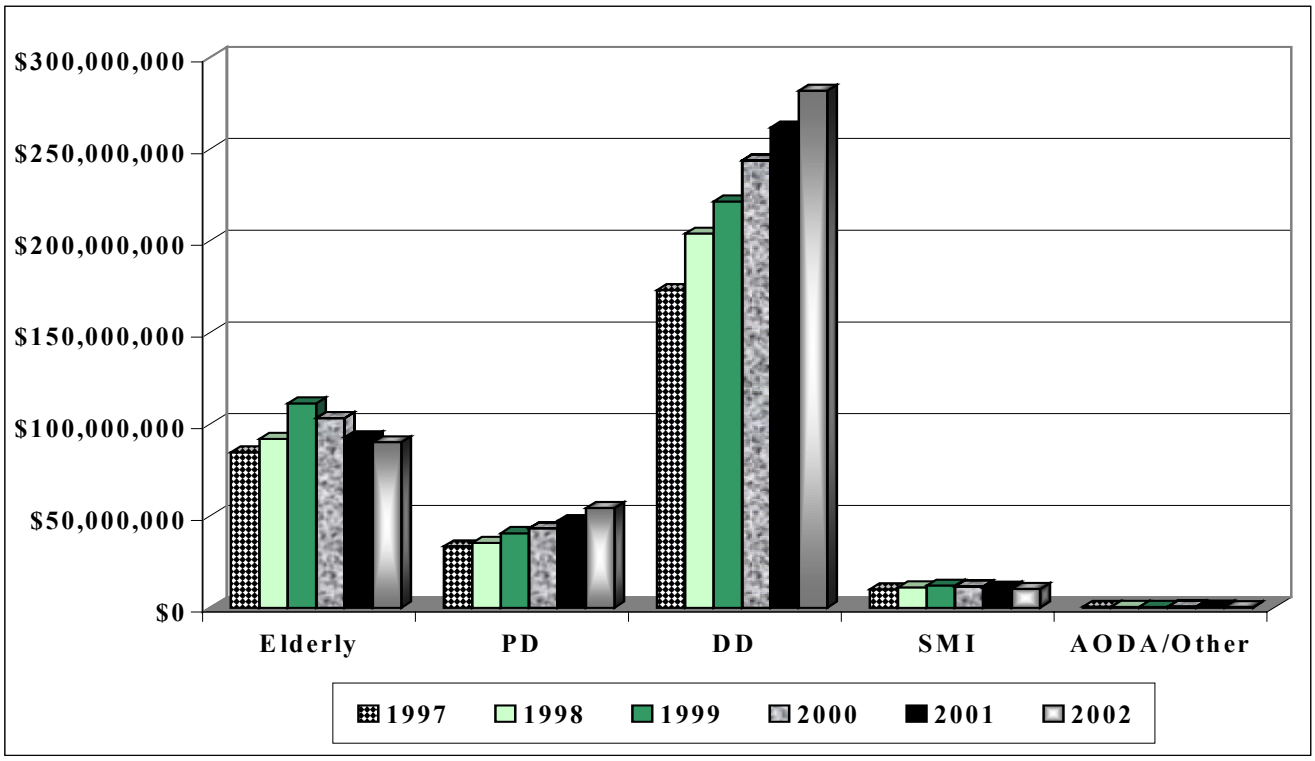
- The elderly received 21% of the funds;
- persons with physical disabilities (PD) received 12% of the funds;
- persons with developmental disabilities (DD) received 64% of the funds;
- persons with severe mental illness (SMI) received 2% of the funds; and
- persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 5
Total COP and Waivers Spending by Target Group



Services for participants are grouped by client characteristics (Figure 6). The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 6
Increase/Decrease in Funding for Community Long-Term Care by Target Group
1997 – 2002



Note: In 2001 and 2002 COP and waiver participants converted to Family Care in five pilot counties.

COP-REGULAR

Community Options Program (COP-Regular) general purpose revenue (GPR) is used in the following ways:

- 24.5 percent of the total COP funds were used for services for COP only participants;
- 38.0 percent were used as match to increase services to waiver eligible people by creating more waiver slots;
- 14.5 percent were used for current waiver participants to provide services that could not be paid for with waiver funds;
- 6.4 percent were used for program and service coordination, and 1 percent for special projects;
- 13.0 percent were used to cover the matching share of expenses for those participants whose cost of care exceeds the waiver allowable rates (exceptionally high cost individuals);
- 3.9 percent of COP-Regular funds were used to conduct assessments and develop care plans for COP and Medicaid waiver eligible people.

In calendar year 2002, $7,144,766 COP-Regular (GPR) dollars were used to fund the match for CIP 1 so counties could earn additional federal funds for persons with developmental disabilities when the average costs exceeded the allowable reimbursement rate. When COP funding is used in this way it is referred to as "overmatch". In addition, $826,228 of COP-Regular (GPR) dollars were used to fund the match for CIP II so counties could earn additional federal funds for persons who were elderly and/or for persons with physical disabilities when the average costs exceeded the allowable reimbursement rate. Another $3,010,211 of COP-Regular funds were used as match to expand the COP-W program.

SERVICE TO PARTICIPANTS WITH ALZHEIMER'S DISEASE INCLUDING OTHER IRREVERSIBLE DEMENTIAS

In 2002, a total of 939 participants, served in the COP, COP-W and CIP II programs, were reported as having an Alzheimer's or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's Disease and Parkinson's Disease). Of these 939 individuals, 18 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were $6,776,341.

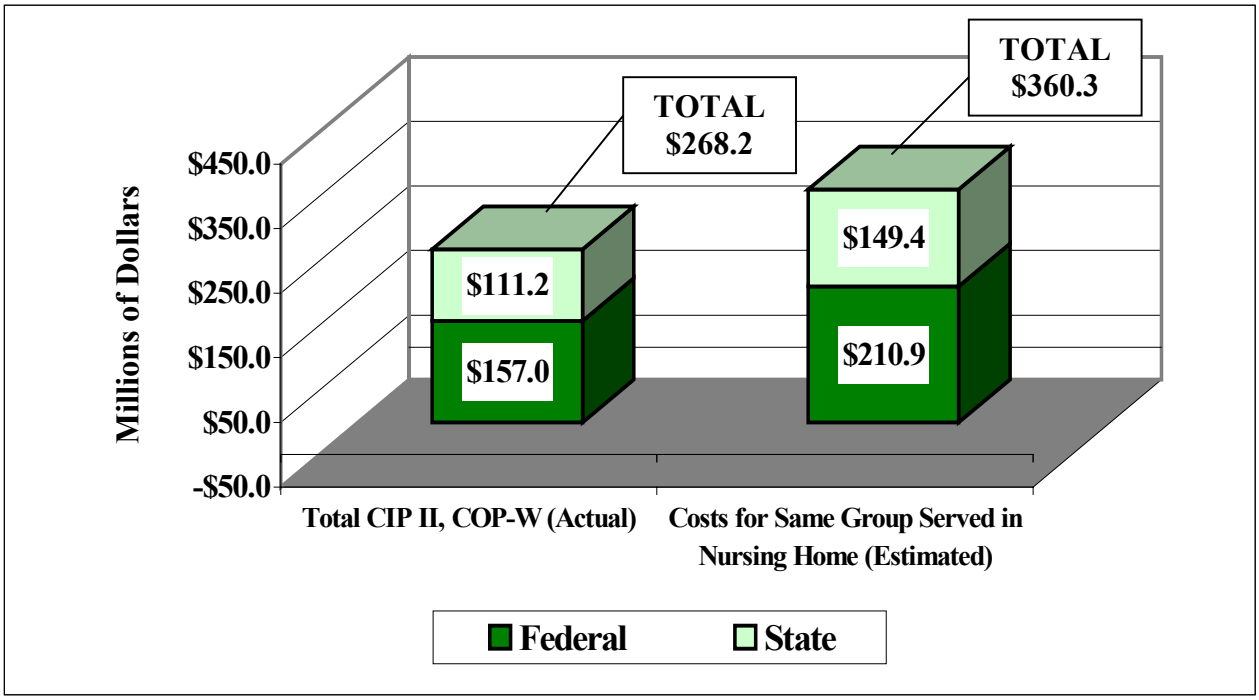
MEDICAID NURSING HOME USE

The Community Options Program and the Medicaid Home and Community-Based Waivers have made possible a lower utilization of nursing home beds by Medicaid participants in Wisconsin. At the same time, COP also filled the gaps in unpaid care provided by family and friends. The extra support services paid for by COP reduce the burden on families who provide substantial amounts of unpaid care. COP has enabled people with long-term care needs to continue to live in their own homes and communities. COP has also been a stimulus to the growth of community care providers in the private sector. Since the beginning of COP and the development of alternatives to nursing home care, days of care paid for by Medicaid in nursing homes have declined. Also, in 2002, CIP II expanded by 510 slots.

COMPARING COP-W PARTICIPANTS' COSTS TO THEIR COSTS IF THEY WOULD HAVE RECEIVED NURSING HOME CARE

Figure 7 illustrates the public costs for participants served with CIP II & COP-Waiver, and compares Medicaid costs for these same participants if they would have been served in a nursing home. The total state and federal costs are compared below if the participants, at the same level of care, were served in a nursing home.

FIGURE 7
Actual Annual 2002 CIP II and COP-W Costs vs. Estimated Care in Nursing Home



The management, monitoring and attention to program cost effectiveness for COP and COP-W are carried out in a number of ways. For additional information on costs of care in the community and in nursing homes, see Table 21 on Page 16.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through its Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services are generally non-medical in nature. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The waiver services provided, their rate of utilization, and the total costs for each service are outlined in the table below. The total cost of Medicaid fee for service card costs for these waiver participants was $107,950,951.

TABLE 18
Total 2002 Total Medicaid Costs for CIP II and COP-W

Total CIP II and COP-W Service Costs	$130,173,445
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$107,950,951
Total 2002 Medicaid Expenditures for CIP II and COP-W Recipients	**$238,124,396**

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 19
2002 CIP II and COP-W
Service Utilization and Costs

CIP II and COP-W Medicaid Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	99.39	$16,339,501	12.55
Supportive Home Care/Personal Care	80.43	54,690,377	42.01
Adult Family Home	4.40	8,575,655	6.59
Residential Care Apartment Complex	1.72	2,869,994	2.20
Community Based Residential Facility	17.43	28,672,824	22.03
Respite Care	3.96	1,561,025	1.20
Adult Day Care	5.67	3,013,619	2.32
Day Services	1.58	1,241,863	.95
Daily Living Skills Training	1.38	1,483,589	1.14
Counseling and Therapies	4.08	581,511	.45
Skilled Nursing	3.20	168,422	.13
Transportation	23.33	1,977,063	1.52
Personal Emergency Response System	38.36	1,244,598	.96
Adaptive Equipment	18.46	2,212,591	1.70
Communication Aids	2.01	61,516	.05
Medical Supplies	22.26	1,234,468	.95
Home Modifications	4.19	1,550,977	1.19
Home Delivered Meals	26.21	2,693,852	2.07
Total Medicaid Waiver Service Costs		**$130,173,445**	

Note: Totals may not equal 100% due to rounding.

TABLE 20 - 2002 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	3.4%	$5,015,244	4.7%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	70.1%	3,002,062	2.8%
Outpatient Hospital	53.1%	3,841,659	3.6%
Lab and X-ray	56.0%	690,316	0.6%
Prescription Drugs	97.7%	35,797,795	33.2%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	47.1%	2,846,519	2.6%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5.3%	335,608	0.3%
Dental Services	15.9%	427,977	0.4%
Nursing (Nurse Practitioner, Nursing Services)	0.2%	684,367	0.6%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	62.1%	12,305,061	11.4%
Personal Care (Personal Care, Personal Care Supervisory Services)	33.0%	28,086,056	26.0%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPDST, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	53.7%	14,918,287	13.8%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$107,950,951**	

Notes: Totals may not equal 100% due to rounding. In 1996, Wisconsin Medicaid restructured CIP II and COP-W Medicaid card service reporting to comply with changes in federal Medicaid reporting requirements.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed.

Table 21 below indicates total public funds spent per capita on an average daily basis for nursing home and waiver care. It also indicates the breakdown between federal spending and state and/or county spending for each funding source.

TABLE 21
2002 Average Public Costs for
CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2002	Medicaid Program Per Diem	$36.29	$15.05	$21.24	$87.46	$36.27	$51.19			
	Medicaid Card	30.10	12.48	17.62	12.87	5.34	7.53			
	Medicaid Costs Subtotal[2]	$66.39	$27.53	$38.86	$100.33	$41.60	$58.73	$33.94	$14.07	$19.87
	COP – Services w/Admin.	3.59	3.59	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.55	0.55	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.74	0.72	1.02	0.12	0.05	0.07			
	Community Aids	0.20	0.08	0.12	unk.	unk.	unk.			
	Other	2.29	0.95	1.34	n/a[4]	n/a[4]	n/a[4]			
	Total	**$74.76**	**$33.42**	**$41.34**	**$100.45**	**$41.65**	**$58.80**	**$25.69**	**$8.23**	**$17.46**

When all public costs are counted, expenses for CIP II and COP-W participants averaged $74.76 per person per day in 2002, compared to $100.45 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-W during 2002 was $25.69 less than the cost of nursing home care, compared to a difference of $29.70 in 2001.

TABLE 22
2001 Average Public Costs for
CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2001	Medicaid Program Per Diem	$31.04	$12.69	$18.35	$84.56	$34.58	$49.98			
	Medicaid Card	30.36	12.42	17.94	12.24	5.00	7.24			
	Medicaid Costs Subtotal[2]	$61.40	$25.11	$36.29	$96.80	$39.58	$57.22	$35.40	$14.47	$20.93
	COP – Services w/Admin.	2.41	0.99	1.42	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.49	0.20	0.29	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.11	0.04	0.07	unk.	unk.	unk.			
	Other	1.08	0.44	0.64	n/a[4]	n/a[4]	n/a[4]			
	Total	**$67.20**	**$27.48**	**$39.72**	**$96.90**	**$39.62**	**$57.28**	**$29.70**	**$12.14**	**$17.56**

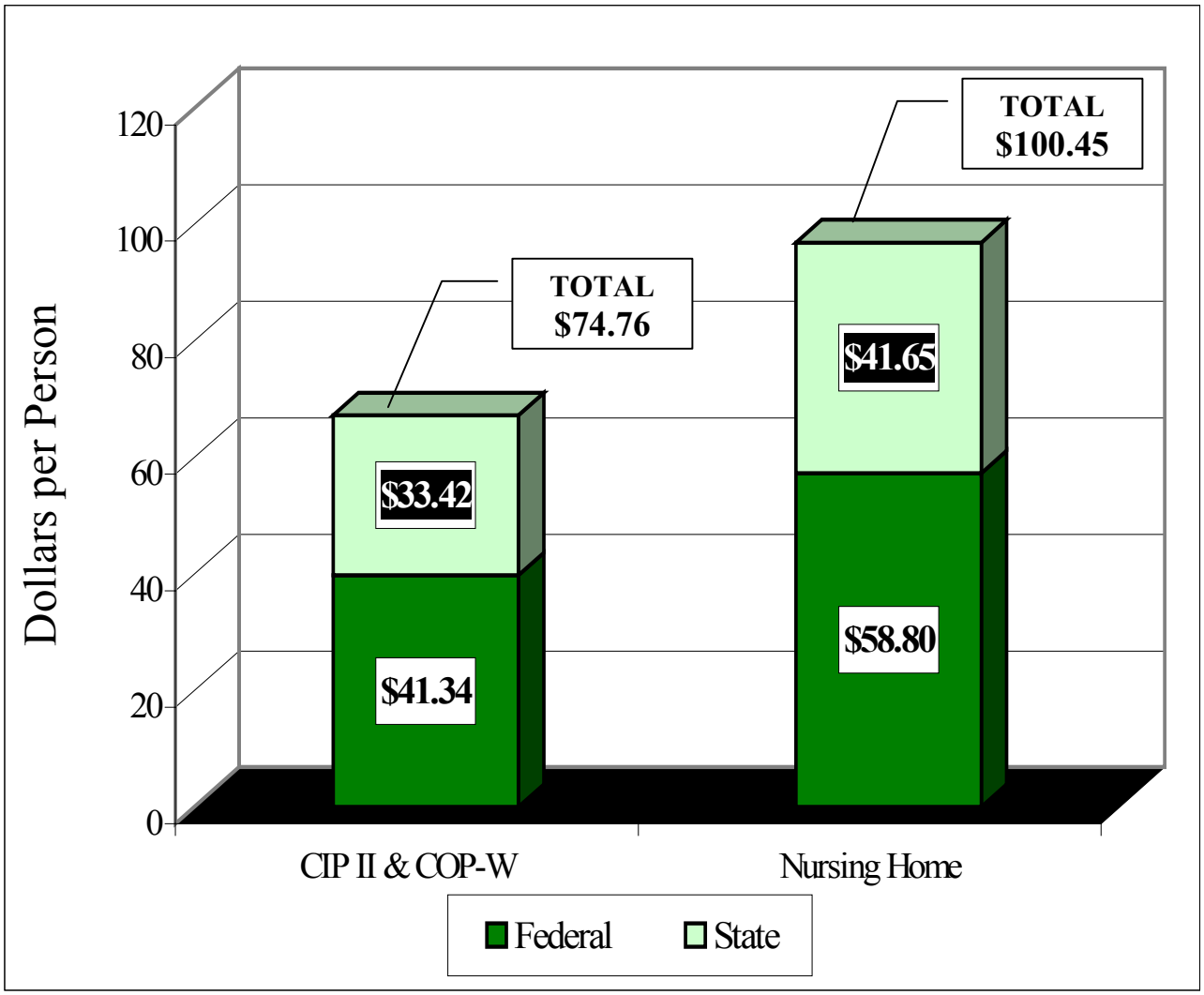
The following footnote references are for Table 21 and Table 22:

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.
4. This category applies only to community care.

COST EFFECTIVENESS

A total of 3,586,855 service days were provided to 13,017 CIP II and COP-W participants during 2002. Therefore, the total public cost of care for waiver participants in 2002, based on actual days of service, was $268,153,280 ($74.76 per day for 3,586,855 days). If the 13,017 individuals had spent the same 3,586,855 days in nursing homes at the average daily public cost for nursing home care, the total cost of serving them in 2002 would have been $360,299,585 ($100.45 per day for 3,586,855 days). The total public spending on behalf of these individuals is estimated to have been $92,146,305 less than if they had resided in nursing homes for the same length of time. Figure 8 below compares actual average daily per capita costs.

FIGURE 8
CIP II & COP-W vs. Nursing Home Care in 2002
Average Public Costs per Day



CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons (Table 21), while calculated using actual costs of care for waiver participants and nursing home residents, may be influenced by differences in the care needs of these two populations. In 2002, 71 percent of CIP II and COP-W participants were rated at the intermediate care facility (ICF) level and 29 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2002 were 12 percent ICF and 88 percent SNF, based on aggregate calendar year nursing home days of care. The significance of any care level difference that exists can be determined by re-estimating average daily and total public costs after adjusting the reported care level proportions.

Based on data supplied for the Department's annual cost report to the Center for Medicare and Medicaid Services, the actual 2002 nursing home Medicaid per diem for ICF residents was approximately $72.77. For SNF residents the Medicaid per diem was approximately $92.25. If the proportions of nursing home residents receiving care at the ICF and SNF levels had been equal to the proportions reported for CIP II and COP-W participants (71 percent ICF and 29 percent SNF), estimated costs to Medicaid for nursing home care would have been $606,705,551 instead of $676,429,734. Given that there were 7,734,539 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2002, this level of total Medicaid spending would have translated to an average per diem across care levels of $78.44 (Table 23), instead of the previously calculated $87.46 (Table 21).

Assuming the same Medicaid card costs and other expenses, the average daily public cost of nursing home care would have been $91.43 per person (Table 23), instead of $100.45 as reported in Table 21. The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $16.67 instead of $25.69. This represents a difference of 22 percent, compared to 34 percent. Table 23 presents the estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 21 after adjusting the average nursing home per diem in this manner.

Using these adjusted figures, the potential impact of waiver utilization on total public spending can be estimated as it was in the previous section. That is, if the 13,017 waiver participants had spent the same 3,586,855 days residing in nursing homes, they would have incurred total public costs of $327,946,153 ($91.43 per day for 3,586,855 days), compared with the $268,153,280 they incurred while residing in the community**. Assuming equivalent care level proportions**, then, total public spending for CIP II and COP-W participants during 2002 was $59,792,873 less than the predicted cost of nursing home care for a comparable group. This figure is 9 percent less than the $353,449,598 estimated using actual 2002 data, but it still represents a difference in total public costs of 17 percent compared with the cost of an equivalent volume of nursing home care. This revised estimate may represent the lower boundary of the difference in costs attributable to these waivers, while the estimate based on actual costs represents an upper boundary.

TABLE 23
2002 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents Adjusting for Level of Care - Average Cost per Person per Day

Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2002	Medicaid Program Per Diem	$36.29	$15.05	$21.24	$78.44	$32.53	$45.91			
	Medicaid Card	30.10	12.48	17.62	12.87	5.34	5.34			
	Medicaid Costs Subtotal[2]	$66.39	$27.53	$38.86	$91.31	$37.86	$53.45	$24.92	$10.33	$14.59
	COP – Services w/Admin.	3.59	3.59	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.55	0.55	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.74	1.02	1.02	0.12	0.05	0.07			
	Community Aids	0.02	0.08	0.12	unk.	unk.	unk.			
	Other	2.29	0.95	1.34	n/a[4]	n/a[4]	n/a[4]			
	Total	**$74.76**	**$33.42**	**$41.34**	**$91.43**	**$37.91**	**$53.52**	**$16.67**	**$4.49**	**$12.18**

TABLE 24
2001 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents Adjusting for Level of Care - Average Cost per Person per Day

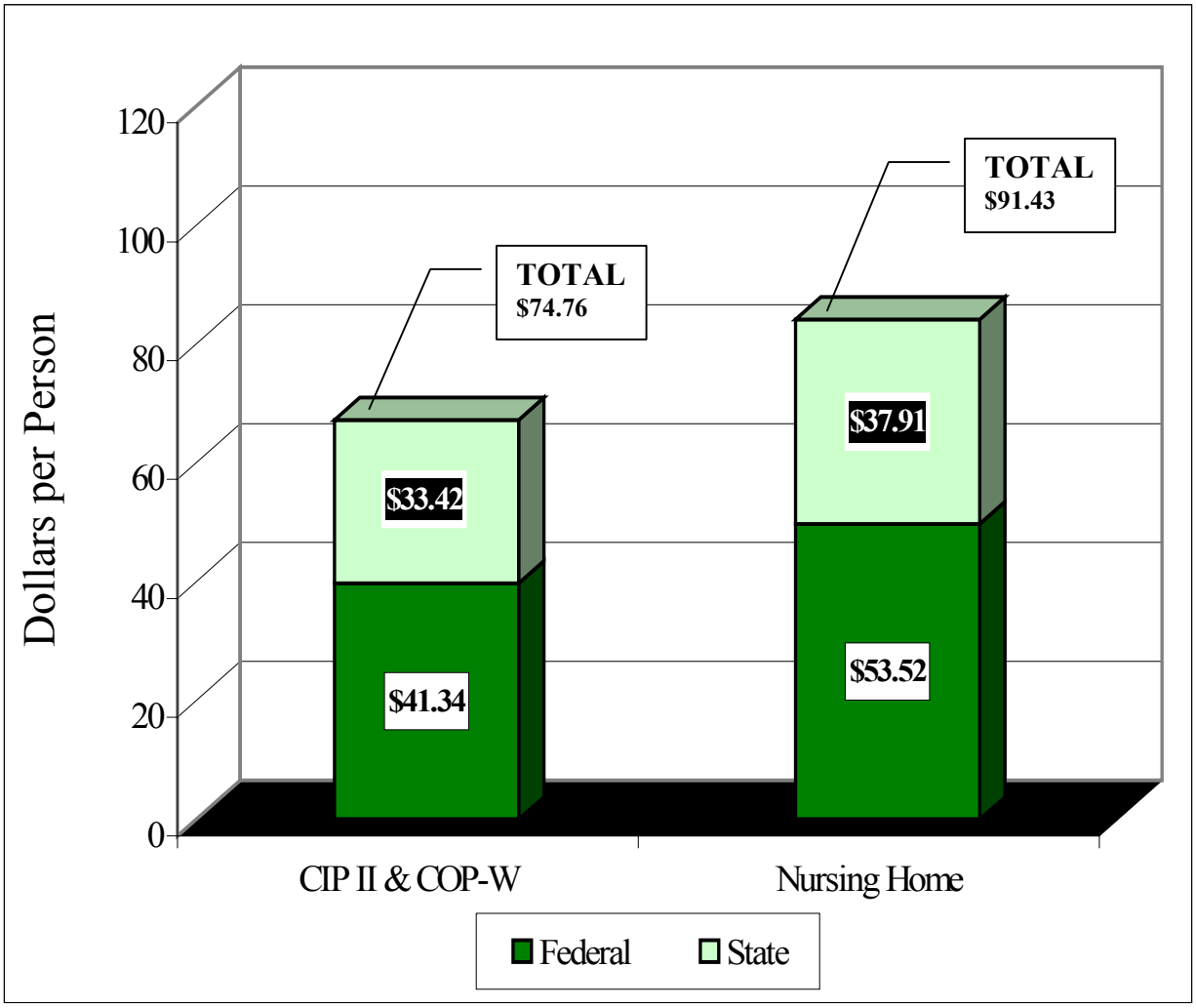
Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2001	Medicaid Program Per Diem	$31.04	$12.69	$18.35	$71.80	$29.36	$42.44			
	Medicaid Card	30.36	12.42	17.94	12.24	5.00	7.24			
	Medicaid Costs Subtotal[2]	$61.40	$25.11	$36.29	$84.04	$34.36	$49.68	$22.64	$9.25	$13.39
	COP – Services w/Admin.	2.41	0.99	1.42	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.49	0.20	0.29	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.11	0.04	0.07	unk.	unk.	unk.			
	Other	1.08	0.44	0.64	n/a[4]	n/a[4]	n/a[4]			
	Total	**$67.20**	**$27.48**	**$39.72**	**$84.14**	**$34.40**	**$49.74**	**$16.94**	**$6.92**	**$10.02**

The following footnote references are for Table 23 and Table 24:

* Nursing home program per diems have been calculated assuming that the proportion of residents rated at the SNF and ICF care levels was the same as that reported for Medicaid Waiver participants in each of the respective years. The figures shown thus represent not actual costs but the costs that would have been incurred had the assumed SNF/ICF proportions prevailed. In nursing homes during 2001, 13 % of residents were rated at an ICF level, and 87% were SNF.

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.
4. This category applies only to community care.

FIGURE 9
CIP II & COP-W vs. Nursing Home Care in 2002
Adjusting for Level of Care
Estimated Average Public Costs per Day



Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program. In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):
The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%.

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY SUPPORTED LIVING ARRANGEMENTS (CSLA-WAIVER):
A Medicaid-funded waiver program that serves the same target group as CIP IB. CSLA provides funds that enable individuals to be supported in their own homes. The program began as a demonstration in some counties in 1992 and was expanded statewide January 1, 1996.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

BRAIN INJURY WAIVER:
A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 475 cases in 2002. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 91 percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Medicaid financial eligibility as approved in state plan*
- ✓ *Cost share*
- ✓ *Spend down*

Findings: 96 *percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Health form*
- ✓ *Functional screen*

Findings: 88 *percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

Monitoring Components:
- ✓ *Individual Service Plan (ISP) developed and reviewed with participant*
- ✓ *Services waiver allowable*
- ✓ *Services appropriately billed*

Findings: 86 *percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:
- ✓ *Waiver-billed services met necessary standards and identified needs*
- ✓ *Care providers appropriately trained and certified*

Findings: 86 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

Monitoring Components:
- ✓ *Services accurately billed*
- ✓ *Only waiver allowable providers billed*
- ✓ *Residence in waiver allowable settings during billing period*

Findings: 83 *percent compliance was found in these categories. A process has been implemented to assist in improving billing accuracy; however, reports could not be generated to assist local agencies in identifying and correcting such errors due to a vacant state position. This vacancy has now been filled. Disallowances were taken.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Contracting requirements have been met*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: 98 *percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.*

CORRECTIVE ACTION

A written report of each monitoring review was provided to the director of the local agency responsible for implementing the waiver participant's service plan. The reports cited any errors or deficiencies and required that the deficiency be corrected within a specified period of time, between 1 and 90 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. All agencies complied by modifying their practices and acknowledging the deficiencies.

In 2002, a total of 36 agencies were monitored, 34 with full reviews and 2 with reviews of newly implemented internal recertification systems. In 28 instances, disallowances were taken from counties where retroactive corrections could not be implemented. The total disallowance for the 28 agencies combined was $92,891. Disallowances were taken in areas including billing of non-allowable services, data entry errors, lack of documentation for billed services, billing during a period of ineligibility for waiver services, and inaccurate collection of cost share.

PROGRAM QUALITY

During 2002, 475 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:

- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:

- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:

- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

Table 25 combines and summarizes the findings of the survey. Satisfaction in substitute (residential) care settings is somewhat lower than satisfaction with services in one's own home.

Table 25
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	95%
Good communication with care manager	95%
Care manager is responsive	96%
Active participation in care plan	93%
Satisfaction with in-home workers	96%
Substitute care services are acceptable	96%
Satisfaction with substitute care living arrangement	87%

QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. An overview of those projects is listed below:

- Provide issue specific or county specific intensive monitoring or training where significant errors have been identified. Repeat monitoring where necessary;
- Develop issue specific technical assistance documents. Quarterly, this includes answers to the most frequently asked questions. The document entitled "WaiverWise" is now available on the Department of Health and Family Services website;
- Conduct statewide training in the areas of Fiscal Management, Advanced Care Manager/Economic Support Training, and Plan Development and Care Management Techniques;
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance;
- Produce and distribute case specific fiscal reports containing potentially correctable reporting errors; and
- Conduct enhanced interviews to determine customer satisfaction.

Irene Anderson and Kate Fitzgerald prepared this report with assistance from the staff in the Bureau of Aging and Long Term Care Resources and HSRS programming staff. We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

Irene Anderson
Bureau of Aging and Long Term Care Resources
P.O. Box 7851
Madison, WI 53707-7851
Phone: (608) 266-3884
Fax: (608) 267-2913
E-mail: anderil@dhfs.state.wi.us